STATE OF MARYLAND HIV/CD4 Laboratory Reporting Form

Lab Accession #														
Medical Record #														
Patient Name	 First					Last					MI			
Patient Address							Last							
Address														
Address	Address						Apt.							
City							Si	tate		ZIP Cod	'e			
Last 4 SSN# Date of Birth Sex 1 = Male 2 = Female 9 = Not specified														
Ethnicity (Check one) Hispanic Not Hispanic Unknown (Check all that apply) Asian Black or African American White Unknown														
Specimen Collection	Date M M	D D Y	YY	Υ	Spe	cime	n Typ	е		llood Plasma Serum	4 = Urir 5 = Ora 6 = Oth	l Fluid		
Test Performed/Resul	lt							_						
HIV + (Check all that apply)							CD4							
☐ HIV-1 Western Blot: ☐ Positive						CD4: cells/ul								
IFA: ☐ Reactive							·	0 D4.				Cells/ul		
Viral Load:						CD4 %:								
Undetectable copies/ml														
ORDERING PHYSICIA	<u>.N</u>													
Name														
First				La	st									
Phone # Facility Code														
Address														
Building or Facilit	ty Name													
Address						Suite/Room								
City						State ZIP Code								
TESTING LABORATO	RY													
	-					Specim 	en forwa	arded to	Refere	nce Lab	oratory			
CLIA#			Sent to	CLIA	#									
Date Form Completed M M D D Y Y Y Y Person Completing Form														